

Edward Cancer Centers

120 Spalding Drive; Suite 111; Naperville, IL 60540
Phone: 630/646-2273 Fax: 630/548-6617
177 E. Brush Hill Road
Elmhurst, IL 60126
Phone: 630/646-2273 Fax: 331/221-3857

24600 West 127th Street; Plainfield, IL 60585
Phone: 630/646-2273 Fax: 630/548-6617

Reclast Infusion Therapy Orders

Patient Name: _____ DOB: _____

*****Please include current history and physical and any recent labs/tests, if applicable*****

PLEASE ATTACH COPY OF INSURANCE CARD WITH THIS ORDER

**Pre-Authorization # or
Call Reference #:** _____

(Ordering Physician Office is Responsible to Obtain Authorization/Referral)

Check if insurance requires drug to be provided by specialty pharmacy

**Contact Name and Phone Number
of Insurance Company:** _____

If you have any questions regarding pre-authorizations, please contact (630) 527-3788 and ask for the billing department.

Patient's Weight: _____

PRIMARY DIAGNOSIS (ICD-10 REQUIRED): _____

SECONDARY DIAGNOSIS (ICD -10 REQUIRED): _____

(The following dx codes do not require secondary diagnosis: M88.9; M81.0; M84.453A)

Pre-Infusion Requirements:

This patient has a calculated creatinine clearance of greater than or equal to 35ml per minute and a normal serum calcium level (**labs must be done within 2 weeks of infusion**)

Yes No

**Date of Lab Results
(PLEASE ATTACH
COPY):** _____

Required lab work prior to Reclast may be done at Cancer Center on day of infusion

Yes No

Patient currently taking calcium and Vitamin D supplements

Yes No

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Dosing Guidelines:

- Senile Osteoporosis: Reclast 5mg IVPB over 20 minutes once yearly.
- Paget's Disease Reclast 5mg once yearly or as determined

NOTE: Patients must be off oral bisphosphonates (Fosamax, Boniva, etc.) for one month prior to Reclast.

In the event of a hypersensitivity reaction during the infusion of this medication, we will implement the reaction protocol. A designated nurse practitioner will evaluate your patient and your office will receive notification of the event.

In the event that your patient has a central line, it will be used per the Cancer Center protocol, unless otherwise directed.

Physician Signature: _____ Date: _____

Ordering Physician NPI: _____ Edward Hospital NPI: 1427069632

Physician Name (Please Print) Office Phone Fax Number

Revision/Review Date: 01/27/2021